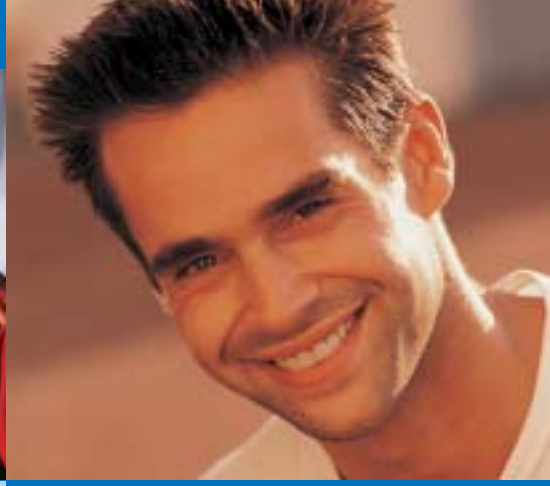

Health Insurance and Nutrition

APPLICATION

access NY health care

for Children, Adults and Families

Medicaid

Child Health Plus

family health plus

Pcap

WIC

INSTRUCTIONS

CONFIDENTIALITY STATEMENT All of the information you provide on this application will remain confidential. The only people who will see this information are the enrollment facilitators and the state or local agencies and health plans who need to know this information in order to determine if you (the applicant) and your household members are eligible. The person helping you with this application cannot discuss the information with anyone, except a supervisor or the state or local agencies or health plans which need this information.

INSTRUCTIONS for completing this Access NY Health Care application. This application is not for people applying for long term care services (such as nursing home care, personal care or home care).

PLEASE READ the entire application, instructions and document checklist before you fill out the application. If this application is ONLY for children or a pregnant woman, complete Sections A through H and Section K. Other applicants must complete all sections. (Refer to the documentation checklist for acceptable required documents. If you need more space to list information, please use the ADDITIONAL INFORMATION page.)

SECTION A Contact Information

In this section, we ask for information about how to contact the applicants. The home address is where the persons applying for health insurance live. The mailing address, if different, is where the health insurance cards and all notices will be sent.

SECTION B Household Information

List the names of all the people who want to apply for or are already receiving Child Health Plus, Family Health Plus, Medicaid, or PCAP. If a parent, step-parent or spouse of a person listed lives in the household but is not applying, list his/her name also. You may list other members of your household, at your option (for example, a dependent child under the age of 21). Listing the other household members may allow us to give you a higher eligibility level or allow us to look at your eligibility under a different category. List the head of household on line 1. Fill out the information requested for each listed person.

- **Is this person pregnant?** This information helps us determine the size of your family. A pregnant woman counts as two people.
- **Relationship to Head of Household.** Show how each person is related to the head of household (the person listed on line 1) e.g., spouse, child/step-child, niece, nephew, etc.

- **Does this person want health insurance?** Each person applying for health insurance will only be enrolled in the program they qualify for: Medicaid, Child Health Plus A or B, PCAP or Family Health Plus.
- **Social Security Number.** A social security number should be provided for all persons applying if it is available, but is not needed for pregnant women or any household member who is not applying for health insurance.
- **Race/Ethnic Group.** This information is optional. It is asked to make sure all people have access to the programs. If you fill out this information, use the code shown on the application that best describes the person's race or ethnic background. You may pick more than one.

SECTION C Health Insurance

It is important to tell us whether anyone in your household has health insurance, or is covered by someone else's insurance, for several reasons:

- In certain cases, you may not be able to enroll in some programs;
- For certain applicants, we will subtract the cost of the health insurance from your income;
- For future medical bills, it helps us determine which insurance should pay first.

List the names of any persons in your household who are already enrolled in Medicaid, Child Health Plus A or B, Family Health Plus or PCAP and their identification numbers. This may help us reduce paperwork for you.

List all persons covered by any other private health insurance or Medicare and provide the information requested. If this coverage is ending soon, give the date the coverage will end.

To help you answer whether anyone has access to health insurance through a state health benefits plan, the following describes what we mean:

- **State Health Benefits Plan** means the New York State Health Insurance Program (NYSHIP), which is offered to employees/retirees of NYS government, the State Legislature and the Unified Court System. Some local government agencies and school districts also elect to participate in NYSHIP. If you are not sure, check with your employer.

SECTION D Citizenship

This information is needed only for those people applying for health insurance. Pregnant women do not have to complete this section. To be eligible for health insurance, other persons age 19 and over must be citizens or must fall within one of many immigration categories. Children who are New York State residents and who do not have other health insurance are eligible, regardless of their immigration status.

PUBLIC CHARGE INFORMATION

The Immigration and Naturalization Service (INS) has said that enrollment in Child Health Plus A or B, Medicaid, PCAP or Family Health Plus CANNOT affect a person's ability to get a green card, become a citizen, sponsor a family member, or travel in and out of the country (except if Medicaid pays for long-term care in a place like a nursing home or psychiatric hospital).

The State will not report any information on this application to the INS.

SECTION E Household Income

In this section, list all types of income and the amount received by the people you listed in Section B.

If there is no money coming into the household, explain how the applicants are being supported.

- **Child Care and Adult Dependent Costs** are how much you pay another person to take care of your children or disabled spouse or parent while you are working or going to school. Some of this amount may be subtracted from your monthly earnings.

SECTION F Housing Expenses

Give the monthly cost of housing for your household. This includes your rent, monthly mortgage payment or other housing payment. If you have a mortgage payment, include property taxes and homeowners insurance. If you pay for your heat, list the type of heat that is used (gas, oil, electric).

If this application is only for children under age 19 and/or a pregnant woman, you do not have to provide this information. However, if you do provide it, these applicants may have their benefits continued if their household earnings increase at some time in the future, and they no longer qualify for Medicaid or Child Health Plus A.

SECTION G Illness/Injury

These questions help us determine which program is best for the applicants. You may be able to get more health services if you have a disability or if you have a serious illness or high medical bills. This section also helps us to know if someone else should pay for medical care.

If you have paid or unpaid medical bills from the past 3 months, Medicaid and Child Health Plus A may be able to pay for these costs. If you want us to determine this, check *yes*. **Include copies of the medical bills with this application.**

SECTION H Women Infants and Children (WIC)

WIC is a program to improve the nutrition and health of women, infants, and children. Check *yes* if you would also like to apply for this program. Applying for WIC will not change your eligibility for health insurance. You will still need to visit a WIC office.

STOP. If this application is ONLY for children under age 19 and/or a pregnant woman, go to Section K.

SECTION I Resources

DO NOT COMPLETE THIS SECTION UNTIL YOU MEET WITH THE INTERVIEWER.

Pregnant women and children under age 19 do not have to answer this question.

At the time of the interview, you will be asked about the total value of your resources. Examples of resources include such things as money in a bank account or credit union, stocks, bonds, mutual funds, certificates of deposit, money market accounts, trust funds, 401k plans and property. Resources may also include the value of your car.

The interviewer will assist you to determine what you should count toward the value of your resources. The value of your resources does not make you ineligible for health insurance, but it does affect whether you can get health insurance under Medicaid or Family Health Plus.

You will be told if you need to document your resources.

More instructions on back ▶

SECTION J Information About Parent or Spouse Not Living in the Household

It is important for us to know if health insurance is available to you or your children through a parent or spouse living outside the home.

Pregnant women do not have to answer these questions. To be eligible, all other applying persons, age 19 and over, must be willing to provide information to help us get health insurance from parents or spouses not living in the household, unless there is good cause. An example of good cause is fear of physical or emotional harm to you or a family member. Question 1 refers to the *parent* of any applying child. Question 2 refers to the *spouse* of anyone applying.

Children may still get health insurance from the State if a parent is not willing to provide this information.

SECTION K Health Plan Selection

CHILD HEALTH PLUS B AND FAMILY HEALTH PLUS:

If you are determined eligible for Child Health Plus B or Family Health Plus, you must select a health plan in order to receive medical care. If you want to keep the doctor you have now, you need to join a health plan that your doctor belongs to. If you want to pick a new doctor or to get the code for a doctor or health center, call the selected plan for help. Once enrolled in a health plan, you must use the doctors and hospitals under that plan.

MEDICAID, PCAP AND CHILD HEALTH PLUS A:

Some people enrolled in Medicaid, PCAP or Child Health Plus A will be required to join a health plan. Others will not. If you or a family member are found eligible for Medicaid, PCAP or Child Health Plus A, and you are in a county that requires people to be in a health plan, we will enroll you in the same plan you chose, if it provides Medicaid. If you are in a county that does not require people to be in a health plan, we will still enroll you in the plan you chose, unless you tell us that you do not want to be in this plan by checking the box in this section. Your interviewer will discuss this with you.

Child Health Plus B Premium

There are no premiums for Medicaid, PCAP, Family Health Plus and Child Health Plus A. There may be a monthly premium for Child Health Plus B. **All premiums due must be submitted with this application.** To determine if you need to pay a premium based on your monthly income, use the chart below.

To estimate your premium, count the income of anyone included in your family size. Family size is determined by adding up:

- the number of children applying;
- the number of parents or step-parents living with them; and
- the number of non-applying siblings under the age of 21 living with them.

Family Size	Free	$9 per Child per Month (max. $27)	$15 per Child per Month (max. $45)	Full Premium per Child
1	$ 1,241	$ 1,723	$ 1,940	Over $ 1,940
2	$ 1,665	$ 2,311	$ 2,603	Over $ 2,603
3	$ 2,089	$ 2,899	$ 3,265	Over $ 3,265
4	$ 2,513	$ 3,488	$ 3,928	Over $ 3,928
5	$ 2,937	$ 4,076	$ 4,590	Over $ 4,590
For each additional person add:	$ 424	$ 589	$ 663	

** Effective January 1, 2004. Income levels change annually.*
Note that coverage for children under age one is free at higher income levels.

DO YOU HAVE QUESTIONS OR NEED HELP COMPLETING THIS FORM?

CALL TOLL-FREE

For Children: 1-800-698-4543

For Adults: 1-877-9FHPLUS

ALL HELP IS FREE

(1-877-898-5849 TTY line for the hearing impaired)

READ THE TERMS RIGHTS AND RESPONSIBLITIES SECTION ON THE LAST PAGE AND SIGN AND DATE THE BOTTOM. EACH APPLYING ADULT MUST SIGN.

Medicaid | Child Health Plus | family health plus | Pcap | WIC

State of New York
George E. Pataki, Governor

Department of Health
Antonia C. Novello, M.D., M.P.H., Dr. P.H., Commissioner

ACCESS NY HEALTH CARE

Child Health Plus / Family Health Plus / Medicaid / PCAP / WIC

PLEASE READ the entire application and INSTRUCTIONS before you fill it out.
Print clearly in blue or black ink. If you need more room for any section, attach the Additional Information page.
An incomplete application cannot be processed and will result in a delay of coverage.

Section A Contact Information

Please tell us who you are and how to contact you.

First Name	Middle Initial	Last Name

Please give us a number where you can be reached if we need to contact you for more information:	Phone #	Another Phone #	Primary Language Spoken

HOME ADDRESS of the persons applying for health insurance	**Street**			**Apt#**
	City	**State**	**Zip Code**	**County**
MAILING ADDRESS of Contact Person, if different	**Street**			**Apt#**
	City	**State**	**Zip Code**	**County**

Section B Household Information

List the head of household on line 1. List the names of the persons applying for or already receiving Child Health Plus, Family Health Plus, Medicaid, or PCAP. You **must** also list the name of any parent, step-parent or spouse of an applying person who lives in the household, even if the person is not applying. You **may** list other members of your household at your option (for example, a dependent child under the age of 21). **Listing the other household members may allow us to give you a higher eligibility level.**

	Name First, Middle Initial, Last	Date of Birth	Sex F/M	Is this person pregnant?	Is this person a parent of any applying child?	Relationship to Head of Household	Does this person want health insurance? (Yes or No)	APPLICANTS ONLY: Social Security Number (if available) *Not needed for pregnant women*	APPLICANTS ONLY: Race/ Ethnic Group *(See Codes)*
01	Maiden Name, if any:		☐ F ☐ M	☐ Yes ☐ No	☐ Yes ☐ No	HEAD OF HOUSEHOLD	☐ Yes ☐ No		
02	Maiden Name, if any:		☐ F ☐ M	☐ Yes ☐ No	☐ Yes ☐ No		☐ Yes ☐ No		
03	Maiden Name, if any:		☐ F ☐ M	☐ Yes ☐ No	☐ Yes ☐ No		☐ Yes ☐ No		
04	Maiden Name, if any:		☐ F ☐ M	☐ Yes ☐ No	☐ Yes ☐ No		☐ Yes ☐ No		
05			☐ F ☐ M	☐ Yes ☐ No	☐ Yes ☐ No		☐ Yes ☐ No		
06			☐ F ☐ M	☐ Yes ☐ No	☐ Yes ☐ No		☐ Yes ☐ No		
07			☐ F ☐ M	☐ Yes ☐ No	☐ Yes ☐ No		☐ Yes ☐ No		
08			☐ F ☐ M	☐ Yes ☐ No	☐ Yes ☐ No		☐ Yes ☐ No		
09			☐ F ☐ M	☐ Yes ☐ No	☐ Yes ☐ No		☐ Yes ☐ No		

Is anyone in the household a veteran? ☐ Yes ☐ No

If Yes, Name:

Race/Ethnic Affiliation Codes: *(optional)*

A = Asian
B = Black or African American
H = Hispanic or Latino
I = Native American or Alaskan Native
P = Native Hawaiian or other Pacific Islander
W = White
U = Unknown

Section C Health Insurance

You or your family may still be eligible even if you have other health insurance.

1. Does anyone in the household already get Medicaid, Family Health Plus, Child Health Plus or PCAP? ☐ Yes ☐ No

If Yes

Name	CIN/ID#	Name:	CIN/ID#
Name:	CIN/ID#	Name:	CIN/ID#

2. Does anyone who is applying have Medicare? ☐ Yes ☐ No Medicare #

3. Does anyone who is applying already have other health insurance? ☐ Yes ☐ No

If Yes

Name of Policy Holder		
Insurance Company Name	**Group/Policy #**	**Monthly Cost** $
Person(s) Covered	**End Date of Coverage**	
Name of Policy Holder		
Insurance Company Name	**Group/Policy #**	**Monthly Cost** $
Person(s) Covered	**End Date of Coverage**	

4. **Is the parent/step-parent of any child applying a public employee who can get family coverage through a state health benefits plan?** (see instructions) ☐ Yes ☐ No

If Yes Does the public agency where that person works pay all or part of the cost of this health plan? ☐ Yes ☐ No

5. **In the past 6 months, has anyone who is applying lost or cancelled any type of health insurance that was provided through an employer?** (If no, skip to Section D) ☐ Yes ☐ No

If Yes

Your answer to this question will help us understand the reasons why people change their health insurance.

Why do the person(s) no longer have the health insurance? *(CHECK ONLY ONE)*

☐ 1. The person who had the insurance no longer works for the employer that provided the insurance.
☐ 2. The employer stopped offering health insurance.
☐ 3. The employer stopped offering health insurance for the child(ren) or stopped paying for health insurance for the child(ren) but continued to cover the working parent.
☐ 4. The cost of the health insurance went up and it was no longer affordable.
☐ 5. Child Health Plus or Family Health Plus costs less than the insurance the person(s) used to have.
☐ 6. Child Health Plus or Family Health Plus offers better benefits than the insurance the person(s) used to have.

Section D CITIZENSHIP

Pregnant women do not have to complete this section. This information is needed only for those people applying for health insurance. Almost all children are eligible for health insurance regardless of immigration status.

Is everyone who is applying a U.S. citizen? *(if yes, skip to Section E)* ☐ Yes ☐ No

If NO, please give the following information for anyone applying for health insurance who is not a U.S. Citizen.
Your answers to these questions will be kept completely confidential.

First Name	M.I.	Last Name	Does this person belong to any of the categories listed below? *Check the appropriate box.*	If either A or B, enter date when the person entered the United States (mm/dd/yy)
			☐ A ☐ B ☐ None	
			☐ A ☐ B ☐ None	
			☐ A ☐ B ☐ None	
			☐ A ☐ B ☐ None	
			☐ A ☐ B ☐ None	
			☐ A ☐ B ☐ None	

A: Check A if the person is under one of the following categories:
- Legal Permanent Resident (green card holder)
- Asylee
- Refugee
- Amerasian
- Cuban/Haitian Entrant
- Withholding of Deportation
- Parolee for at least one year
- Conditional Entrant
- Native American born in Canada who is at least 50% Native American
- Some battered immigrants and/or children

B: Check B if the person is under one of the following categories:
- Order of Supervision
- Stay of Deportation
- Voluntary Departure
- Deferred Action status
- Suspension of Deportation
- Parolee for less than one year
- Covered by an approved immediate relative petition
- Properly filed or granted application for adjustment of status
- Has lived continuously in the United States since before January 1, 1972
- Living in the United States with the knowledge and permission or acquiescence of the INS and whose departure INS does not contemplate enforcing.

Section E Household Income

List the types of money and the amount received by everyone listed in Section B

Types of Income	Name of Person (Who receives this income?)	List Type of income/ employer name	How much does the person receive? (before taxes)	How often is the income received? (weekly, every two weeks, monthly, other)
Example	Mary Smith	wages/XYZ Company	$350	weekly
Earnings From Work: Includes wages, salaries, commissions, tips, overtime, self-employment				
Does your employer offer health insurance? ❑ Yes ❑ No	If yes, Employer Name:			
Unearned Income: Includes Social Security Benefits, disability payments, unemployment payments, interest and dividends, veteran's benefits, workers' compensation, child support payments/ alimony, rental income				
Contributions: Money from relatives or friends, roomers or boarders (Include money that anyone gives you each month to help meet living expenses)				
Other: Temporary (cash) Assistance or Supplemental Security Income (SSI) payments, student grants or loans				

If no income, please explain
(for example, living with friend or relative):

Do you have to pay for childcare (or for care of a disabled adult) in order to work or go to school? ❑ Yes ❑ No

If Yes			
	Child's/adult's name:	How much? $	How often *(weekly, every two weeks, monthly)*
	Child's/adult's name:	How much? $	How often *(weekly, every two weeks, monthly)*
	Child's/adult's name:	How much? $	How often *(weekly, every two weeks, monthly)*
	Child's/adult's name:	How much? $	How often *(weekly, every two weeks, monthly)*

Section F Housing Expenses

These questions help us determine the best program for the applicants.
Answering these questions is optional if this application is only for children under the age of 19, or a pregnant woman

Monthly housing payment	**Type of heat** (gas, oil, etc.)	**Is heat included in your housing payment?**
$		❑ Yes ❑ No

Section G Illness/Injury

These questions help us determine which program is best for the applicants

Is anyone who is applying blind, disabled, handicapped, or have a chronic illness or special health care need? ❑ Yes ❑ No

If yes,
Names:

Does anyone applying have an injury, illness, or disability that was caused by someone else,
or that could be covered by insurance, other than health insurance (such as homeowner's or auto insurance)? ❑ Yes ❑ No

If yes,
Names:

Does anyone who is applying have unpaid or recently paid medical bills from the past 3 months?
(Medicaid or Child Health Plus A may be able to pay these bills.) ❑ Yes ❑ No

Section H WIC

WIC is a free program that helps women, infants and children get the food they need for good health

If anyone in the household is pregnant, a new mother, or a child under five years of age, would you like to apply for WIC? ❑ Yes ❑ No

STOP: **If this application includes ONLY children under age 19 and/or a pregnant woman, go to Section K. If this application includes other persons, continue with Sections I and J.**

Section I Resources

Skip this section if this application is only for a child(ren) under the age of 19, or a pregnant woman. Adult applicants must answer these questions, but may be eligible regardless of their resources.

Resources include money in a bank or credit union, stocks, bonds, mutual funds, certificates of deposit, money market accounts, 401k plans, trust funds, the cash value of life insurance, motor vehicles, or property that someone owns. Do not count the value of the home. The interviewer will assist you in determining the value of your resources.

The total value of my/our resources is $

Section J Parent or Spouse Not Living in the Household

Pregnant women do not have to answer these questions. All other applying persons, age 19 or over, must be willing to provide information about a parent or spouse living outside the home to be eligible for health insurance, unless there is good cause. Children may still be eligible even if a parent is not willing to provide this information.

1. Does a parent of any applying children live outside the home? (If no, skip to question 2 below.) ❑ Yes ❑ No

If yes, are you willing to give us information to help us get health insurance from the parent, if it is available to him/her? ❑ Yes ❑ No

Is there any reason (good cause) not to help us get health insurance from the parent?
(An example of good cause is that a family member might be harmed in some way.) ❑ Yes ❑ No

2. Does a spouse (husband or wife) of anyone applying live outside the home? (If no, skip to Section K.) ❑ Yes ❑ No

If yes, are you willing to give us information to help us get health insurance from the spouse, if it is available to him/her? ❑ Yes ❑ No

Is there any reason (good cause) not to help us get health insurance from the spouse?
(An example of good cause is that a family member might be harmed in some way.) ❑ Yes ❑ No

Section K Health Plan Selection

Persons eligible for Child Health Plus B and Family Health Plus must join a health plan to receive their health services. Some people enrolled in Medicaid or Child Health Plus A may be required to join a health plan now and others may be required to join one soon. You may also use this section to pick a plan for Child Health Plus A and Medicaid.

NOTE: If you or a family member are found eligible for Medicaid or Child Health Plus A, and are in a county that does not require people to be in a health plan, we will still enroll you in this plan if it provides Medicaid, unless you tell us you do not want us to do this, by writing to the local social services department or checking this box. ❑

Name of Applying Person	SS Number (if available)	Date of Birth	Health Plan	Doctor/ Health Center	Doctor/ Health Center Code (optional)	Dentist

TERMS, RIGHTS AND RESPONSIBILITIES

By completing and signing this application, I am applying for Medicaid, Family Health Plus, Child Health Plus A or B, PCAP, and the Special Supplemental Food Program for Women, Infants and Children (WIC). I understand that this application, notices and other supporting information will be sent to the program(s) for which I want to apply. I agree to the release of personal and financial information from this application and any other information needed to determine eligibility for these programs. I understand that I may be asked for more information. I agree to immediately report any changes to the information on this application.

• I understand that I must provide the information needed to prove my eligibility for each program. If I have been unable to get the information for Medicaid, Family Health Plus, PCAP or Child Health Plus A, I will tell the social services district. The social services district may be able to help in getting the information.

• If I am applying at a place other than a local Department of Social Services, and my children are not found eligible for Child Health Plus A using this application, I can contact the local Department of Social Services to see if my children are eligible for Child Health Plus A on some other basis.

• I understand that workers from the programs for which family members or I have applied may check the information given by me for this application. The agencies that run these programs will keep this information confidential according to 42 U.S.C. 1396a (a) (7) and 42 CFR 431.300-431.307, the WIC regulations at 7 CFR 246.26 (d), and any federal and state laws and regulations.

• By applying for Child Health Plus B, I agree to pay the applicable premium contribution not paid by New York State.

• I understand that Medicaid, Family Health Plus, PCAP, and Child Health Plus will not pay medical expenses that insurance or another person is supposed to pay, and that if I am applying for Medicaid, Family Health Plus, PCAP, or Child Health Plus A, I am giving to the agency all of my rights to pursue and receive medical support from a spouse or parents of persons under 21 years old and my right to pursue and receive third party payments for the entire time I am in receipt of benefits.

• I will file any claims for health or accident insurance benefits or any other resources to which I am entitled. I understand that I have the right to claim good cause not to cooperate in using health insurance if its use could cause harm to my health or safety or to the health and safety of someone I am legally responsible for.

• I understand that my eligibility for these programs will not be affected by my race, color, or national origin. I also understand that depending on the requirements of these individual programs, my age, sex, disability or citizenship status may be a factor in whether or not I am eligible.

• I understand that if my child is on Child Health Plus A or Family Health Plus, he or she can get comprehensive primary and preventive care, including all necessary treatment through the Child/Teen Health Program. I can get more information on this program from the local Department of Social Services.

• I understand that anyone who knowingly lies or hides the truth in order to receive services under these programs is committing a crime and subject to federal and state penalties and may have to repay the amount of benefits received and pay civil penalties. The New York State Department of Tax and Finance has the right to review income information on this form.

SOCIAL SECURITY NUMBER

WIC, PCAP, and Child Health Plus B: SSNs are not required to enroll in Child Health Plus B or WIC. If available, I will include it for children applying for Child Health Plus B and for anyone applying for WIC.

Medicaid, Family Health Plus, Child Health Plus A: SSNs are required for all applicants, unless the person is pregnant or a non-qualified alien. SSNs are not required for members of my household who are not applying for benefits. I understand that this is required by Federal Law at 42 U.S.C. 1320b-7 (a) and by Medicaid regulations at 42 CFR 435.910. SSNs are used in many ways, both within Department of Social Services (DSS) and between the DSS and federal, state, and local agencies, both in New York and other jurisdictions. Some uses of SSNs are: to check identity, to identify and verify earned and unearned income, to see if non custodial parents can get health insurance coverage for applicants, to see if applicants can get medical support, and to see if applicants can get money or other help. SSNs may also be used for identification of the recipient within and between central governmental Medicaid agencies to insure proper services are made available to the recipient. Also, if I apply for other programs in this joint application, those programs will have access to my SSN and could use it in the administration of the program.

FOR MEDICAID AND CHILD HEALTH PLUS A APPLICANTS ONLY

• RELEASE OF EDUCATIONAL RECORDS

I give permission to the Local Department of Social Services and New York State to obtain any information regarding the educational records of my child(ren), herein named, necessary for claiming Medicaid reimbursements for health-related educational services, and to provide the appropriate federal government agency access to this information for the sole purpose of audit.

• EARLY INTERVENTION PROGRAM

If my child is evaluated for or participates in the New York State Early Intervention Program, I give permission to the local Department of Social Services and New York State to share my child's Medicaid eligibility information with my county Early Intervention Program for the purpose of billing Medicaid.

• REIMBURSEMENT OF MEDICAL EXPENSES

I understand that I have a right as part of my Medicaid application, or later, to request reimbursement of expenses I paid for covered medical care, services and supplies received during the three month period prior to the month of my application. After the date of my application, reimbursement of covered medical care, services and supplies will only be available if obtained from Medicaid-enrolled providers.

FAMILY HEALTH PLUS AND MEDICAID MANAGED CARE

I know that in order to receive Family Health Plus benefits, I must join a health plan. I also know that in some counties, joining a health plan is required to receive Medicaid. I have been told whether my county requires Medicaid enrollees to join a health plan.

I have been told what health plans are available in Family Health Plus and in Medicaid. I understand that if I am found eligible for Family Health Plus, I will be enrolled in the Family Health Plus plan I have chosen. I also understand that if I am found eligible for Medicaid instead of Family Health Plus and I am in a county that requires people to be in a health plan, I will be enrolled in the health plan I chose unless that plan does not participate in Medicaid. If I/we are in a county that does not require people to be in a Medicaid health plan, I/we will still be enrolled in the plan I chose, unless I notify my local social services department in writing or on the application, that I/we do not want to be in this plan.

TERMS, RIGHTS AND RESPONSIBILITIES

I have been told the rights and benefits that I will have as a member of a health plan and the benefit limitations of managed care membership. I know that in both Family Health Plus and Medicaid, I must choose a Primary Care Provider (PCP) and that I will have a choice from at least three (3) PCPs in my health plan. I understand that once I enroll in a plan, I will have to use my PCP and other providers in my health plan except in a few special circumstances.

I know that if a child is born to me while I am a member of a health plan, my child will be enrolled in the same plan that I am in. I know that if a child is born to me while I am a member of a Family Health Plus plan that also participates in Medicaid, my child will be enrolled in the same plan that I am in.

• RELEASE OF MEDICAL INFORMATION

I consent to the release of any medical information about me and any members of my family for whom I can give consent: by my Primary Care Provider, any other health care provider or the New York State Department of Health (SDOH) to my health plan and any health care providers involved in caring for me or my family, as reasonably necessary for my health plan or my providers to carry out treatment, payment, or health care operations; by my health plan and any health care providers to SDOH and other authorized federal, state, and local agencies for purposes of administration of the Medicaid, Child Health Plus, PCAP and Family Health Plus programs; and, by my health plan to other persons or organizations, as reasonably necessary for my health plan to carry out treatment, payment, or health care operations. I also agree that the information released may include HIV, mental health or alcohol and substance abuse information about me and members of my family, to the extent permitted by law. If more than one adult in the family is joining a Family Health Plus or Medicaid health plan, the signature of each adult applying is necessary for consent to release information.

• REIMBURSEMENT OF MEDICAL EXPENSES

I understand that if I am determined eligible for Family Health Plus my enrollment will be effective no later than 90 days from the date of submission of a completed application. In the event of an error or delay in my enrollment, Medicaid may be able to reimburse me for reasonable medical expenses I pay as a result of the error or delay. Medicaid may pay my provider for any unpaid expenses only if that provider is a Medicaid enrolled provider.

I agree to having the information on this application shared only among Child Health Plus, Medicaid, PCAP, Family Health Plus, WIC, the health plans indicated in Section K, the local social services district, and the facilitated enrollment organization providing the application assistance. I also consent to sharing this information with any school-based health center that provides services to the applicant(s). I understand this information is being shared for the purpose of determining the eligibility of those individuals applying for Child Health Plus, Medicaid, PCAP, Family Health Plus, and WIC or to evaluate the success of these programs.

By signing this application, I understand that each person applying for Child Health Plus, Medicaid, PCAP, Family Health Plus, and WIC, will be enrolled in the appropriate program, if eligible. I have also read and understand the Terms, Rights and Responsibilities included in this application booklet. I certify under penalty of perjury that everything on this application is the truth as best I know.

DATE _____ SIGNATURE _____

DATE _____ SIGNATURE _____

FOR OFFICE USE ONLY

To be completed by the person assisting with the application

Signature of Person Who Obtained Eligibility Information: X	Employed By: ☐ Community-Based Facilitated Enrollment Agency Specify _____ ☐ Health Plan ☐ Social Services District ☐ Provider Agency

To be completed by Facilitated Enrollers

Facilitated Enroller Name:			Lead Agency:	Lead Org. ID
Application Start Date: mm/dd/yy	Application Sequence Number:	Application Completion Date: mm/dd/yy	Enter Code of Applying Child: Medicaid CHPlus	

To be used by the Local Social Services District

Eligibility Determined By:	Date:	Eligibility Approved By:	Date:
Center Office:	Application Date:	Unit ID:	Worker ID:
Case Name:	District:	Case Type:	Case No:

Effective Date:	MA Disposition Reason Code: ☐ Denial Code ☐ Withdrawal	Proxy: ☐ Yes ☐ No	Registry No:	Ver:

To be used by Child Health Plus Plans

CHPlus Disposition: ☐ Approved ☐ Denied	Denial Code:	Effective Date:	# Children Enrolled (CHPlus):

ADDITIONAL INFORMATION — ACCESS NY HEALTH CARE

Name in Section A	Phone Number

Section B Continued — Household Information

List the names of the persons applying for or already receiving Child Health Plus, Family Health Plus, Medicaid, or PCAP. You **must** also list the name of any parent, step-parent or spouse of an applying person who lives in the household, even if the person is not applying. You **may** list other members of your household at your option (for example, a dependent child under the age of 21). **Listing the other household members may allow us to give you a higher eligibility level.**

	Name First, Middle Initial, Last / Maiden Name, if any:	Date of Birth	Sex F/M	Is this person pregnant?	Is this person a parent of any applying child?	Relationship to Head of Household	Does this person want health insurance? (Yes or No)	APPLICANTS ONLY: Social Security Number (if available) *Not needed for pregnant women*	APPLICANTS ONLY: Race/ Ethnic Group *(See Codes)*
10			☐ F ☐ M	☐ Yes ☐ No	☐ Yes ☐ No		☐ Yes ☐ No		
11			☐ F ☐ M	☐ Yes ☐ No	☐ Yes ☐ No		☐ Yes ☐ No		
12			☐ F ☐ M	☐ Yes ☐ No	☐ Yes ☐ No		☐ Yes ☐ No		

Race/Ethnic Affiliation Codes: *(optional)*

A = Asian
B = Black or African American
H = Hispanic or Latino
I = American Indian or Alaskan Native
P = Native Hawaiian or other Pacific Islander
W = White
U = Unknown

Section C Continued — Health Insurance

You or your family may still be eligible even if you have other health insurance.

1. Does anyone in the household already get Medicaid, Family Health Plus, Child Health Plus or PCAP? ☐ Yes ☐ No

If Yes:

Name	CIN/ID#	Name:	CIN/ID#

2. Does anyone who is applying have Medicare? ☐ Yes ☐ No Medicare #

3. Does anyone who is applying already have other health insurance? ☐ Yes ☐ No

If Yes:

Name of Policy Holder		
Insurance Company Name	Group/Policy #	Monthly Cost $
Person(s) Covered	End Date of Coverage	

Section D Continued — CITIZENSHIP

Pregnant women do not have to complete this section. This information is needed only for those people applying for health insurance. Almost all children are eligible for health insurance regardless of immigration status.

Is everyone who is applying a U.S. citizen? (if yes, skip to Section E) ☐ Yes ☐ No

If NO, please give the following information for anyone applying for health insurance who is not a U.S. Citizen.
Your answers to these questions will be kept completely confidential.

First Name	M.I.	Last Name	Does this person belong to any of the categories listed below? *Check the appropriate box.*	If either A or B, enter date when the person entered the United States (mm/dd/yy)
			☐ A ☐ B ☐ None	
			☐ A ☐ B ☐ None	
			☐ A ☐ B ☐ None	

A: Check A if the person is under one of the following categories:
- Legal Permanent Resident (green card holder)
- Asylee
- Refugee
- Amerasian
- Cuban/Haitian Entrant
- Withholding of Deportation
- Parolee for at least one year
- Conditional Entrant
- Native American born in Canada who is at least 50% Native American
- Some battered immigrants and/or children

B: Check B if the person is under one of the following categories:
- Order of Supervision
- Stay of Deportation
- Voluntary Departure
- Deferred Action status
- Suspension of Deportation
- Parolee for less than one year
- Covered by an approved immediate relative petition
- Properly filed or granted application for adjustment of status
- Has lived continuously in the United States since before January 1, 1972
- Living in the United States with the knowledge and permission or acquiescence of the INS and whose departure INS does not contemplate enforcing.

Section E Continued — Household Income

List the types of money and the amount received by everyone listed in Section B

Types of Income	Name of Person (Who receives this income?)	List Type of income/ employer name	How much does the person receive? (before taxes)	How often is the income received? (weekly, every two weeks, monthly, other)
Example	Mary Smith	wages/XYZ Company	$350	weekly
Earnings From Work: Includes wages, salaries, commissions, tips, overtime, self-employment				
Does your employer offer health insurance? ❑ Yes ❑ No	If yes, Employer Name:			
Unearned Income: Includes Social Security Benefits, disability payments, unemployment payments, interest and dividends, veteran's benefits, workers' compensation, child support payments/ alimony, rental income				
Contributions: Money from relatives or friends, roomers or boarders (Include money that anyone gives you each month to help meet living expenses)				
Other: Temporary (cash) Assistance or Supplemental Security Income (SSI) payments, student grants or loans				

If no income, please explain
(for example, living with friend or relative):

Do you have to pay for childcare (or for care of a disabled adult) in order to work or go to school? ❑ Yes ❑ No

If Yes			
	Child's/adult's name:	How much? $	How often *(weekly, every two weeks, monthly)*
	Child's/adult's name:	How much? $	How often *(weekly, every two weeks, monthly)*

Section F Continued — Health Plan Selection

Persons eligible for Child Health Plus B and Family Health Plus must join a health plan to receive their health services. Some people enrolled in Medicaid or Child Health Plus A may be required to join a health plan now and others may be required to join one soon. You may also use this section to pick a plan for Child Health Plus A and Medicaid.

NOTE: If you or a family member are found eligible for Medicaid or Child Health Plus A, and are in a county that does not require people to be in a health plan, we will still enroll you in this plan if it provides Medicaid, unless you tell us you do not want us to do this, by writing to the local social services department or checking this box. ❑

Name of Applying Person	SS Number (if available)	Date of Birth	Health Plan	Doctor/ Health Center	Health Center Code (optional)	Dentist

DOCUMENTATION CHECKLIST
For Health Insurance

Applicant Name _____ *Application Date* _____

Your enrollment cannot be completed until all checked items are received. Please return these items by _____.
If you need help getting any of these items, let us know.

PROOF OF IDENTITY/DATE OF BIRTH AND RESIDENCE: You must show ONE of the documents listed in both categories to see if you are eligible for health insurance. Discuss this with the person helping you with your application. Photocopies are acceptable.

❑ IDENTITY/DATE OF BIRTH
(not required for recertification)

- ❑ Drivers license/Official Photo identification
- ❑ Passport*
- ❑ Birth certificate*
- ❑ Baptismal/other religious certificate*
- ❑ Official School records
- ❑ Adoption records
- ❑ Official Hospital/doctor birth records*
- ❑ Naturalization certificate*
- ❑ Marriage records

** May also be used to document citizenship or immigration status.*

❑ RESIDENCY/HOME ADDRESS
(this must match the home address in Section A, and the proof must be dated within 6 months of the application)

- ❑ ID card with address
- ❑ Postmarked envelope, postcard, or magazine label with name and date (cannot use if sent to a P.O. Box)
- ❑ Drivers license issued within past 6 months
- ❑ Utility bill (gas, electric, cable), or correspondence from a government agency which contains name and street address
- ❑ Letter/lease/rent receipt with home address from landlord
- ❑ Property tax records or mortgage statement

PROOF OF CURRENT INCOME: You must provide a letter, written statement, or copy of check or stubs, from the employer, person or agency providing the income. Submit all that apply. Provide the most recent proof of income before taxes. The proof must be dated, include the employees name and show gross income for the pay period.

❑ Wages and Salary
- ❑ Paycheck stubs *(4 consecutive weeks)*
- ❑ Letter from employer on company letterhead, signed and dated
- ❑ Income tax return/W-2**
- ❑ Business records

❑ Self-Employment
- ❑ Signed and dated income tax return and all Schedules**
- ❑ Records of earnings and expenses

❑ Unemployment Benefits
- ❑ Award letter/certificate
- ❑ Benefit check
- ❑ Correspondence from NYS Dept. of Labor

Private Pensions/Annuities
- ❑ Statement from pension/annuity

❑ Social Security
- ❑ Award letter/certificate
- ❑ Benefit check
- ❑ Correspondence from Social Security Administration

❑ Child Support/Alimony
- ❑ Letter from person providing support
- ❑ Letter from court
- ❑ Child support/alimony check stub

❑ Worker's Compensation
- ❑ Award letter
- ❑ Check stub

❑ Veteran's Benefits
- ❑ Award letter
- ❑ Benefit check stub
- ❑ Correspondence from Veterans Administration

❑ Military Pay
- ❑ Award letter
- ❑ Check stub

❑ Interest/Dividends/Royalties
- ❑ Statement from bank, credit union or financial institution
- ❑ Letter from broker
- ❑ Letter from agent

❑ Income from Rent or Room/Board
- ❑ Letter from roomer, boarder, tenant
- ❑ Check stub

❑ Support from Other Family Members
- ❑ Signed statement or letter from family member

*** W-2s or income tax returns for other than self-employed may be used for applications prior to April of the following year. If later, you must include another form of documentation.*

DOCUMENTATION CHECKLIST
For Health Insurance

DEPENDENT CARE COSTS:

- ☐ Written statement from day care center or other child/adult care provider
- ☐ Canceled checks or receipts

PROOF OF HEALTH INSURANCE:

- ☐ Insurance policy
- ☐ Certificate of Insurance
- ☐ Insurance card
- ☐ Termination Letter
- ☐ Medicare Card
- ☐ Other _____

IMMIGRATION STATUS: (not needed for pregnant women)

- ☐ INS form I-551 (Green Card)
- ☐ INS form I-94
- ☐ INS form I-220B
- ☐ INS I-210 letter
- ☐ INS form I-181
- ☐ Other INS documentation, or correspondence to or from the INS, that shows that the alien is PRUCOL; that is, the alien is living in the U.S. with the knowledge and permission or acquiescence of the INS, and the INS does not contemplate enforcing the alien's departure from the U.S.

FOR MEDICAID, CHILD HEALTH PLUS A AND FAMILY HEALTH PLUS ONLY

☐ **Citizenship**

- ☐ U.S. Birth Certificate
- ☐ U.S. Baptismal record, recorded within 3 months of birth
- ☐ U.S. Passport
- ☐ Naturalization certificate
- ☐ Official Hospital/doctor birth records

☐ **Resources**
(persons age 19 and over, only if checked by interviewer)

- ☐ Bank Statement
- ☐ Life Insurance policy
- ☐ Deed or Appraisal for Real Estate
- ☐ Copies of stocks, bonds, securities
- ☐ Motor Vehicles—Estimate from dealer, "blue book" value
- ☐ Burial Agreement
- ☐ Trust Fund

PREGNANT WOMEN ONLY

☐ **Proof of Pregnancy**

- ☐ Presumptive Eligibility Screening Worksheet completed by qualified provider
- ☐ Statement from medical professional with expected date of delivery
- ☐ WIC Medical Referral Form

MEDICAID/CHILD HEALTH PLUS A ONLY

For determination of eligibility for medical expenses from the past three months:

- ☐ Proof of income for the month(s) in which the expense was incurred
- ☐ Proof of residency/home address for the month(s) in which the expense was incurred

Family Health Plus
Child Health Plus
Medicaid
PCAP • WIC

access NY health care

> "As Governor, one of my top priorities has been to ensure that all New Yorkers have access to quality, comprehensive health care. With our new single application, we are making it easier for hard working families across the State to enroll in health insurance programs that will keep them healthy and strong."
>
> *Governor George E. Pataki*

Health Insurance

Health insurance is available for most uninsured children under age 19, living in New York State under one of two programs: Child Health Plus A (children's Medicaid) or Child Health Plus B. Almost all children are eligible, regardless of how much your family earns or your child's immigration status.

Health insurance is available under Medicaid and Family Health Plus for most people aged 19 to 64, who have limited income and who are citizens or who fall within one of many immigration categories.

What programs am I eligible for?

One application is used to apply for the following programs: Child Health Plus A and B, Family Health Plus, Medicaid, PCAP, Family Planning and WIC. Based on the information you give us, we will tell you which program you and/or your child(ren) may be eligible for.

What services are covered?

Important services such as regular medical check-ups, prescription drugs, hospital care, eye exams, eyeglasses, mental health services, and much more are covered. Child Health Plus A, Medicaid, and Family Health Plus have an added guarantee for persons under the age of 21, that provides for all necessary treatment through the Child/Teen Health Program. There are no deductibles or co-payments for children's health insurance or for adults eligible for Family Health Plus.

Do I have to pay anything to join?

How much you pay depends on your family income. For most families, health insurance is free. Other families have to pay a small amount.

The chart below shows the amount of income (before taxes) at which you can get free or subsidized health insurance. For children under 19, if your income is more than these amounts, your child can get health insurance for a higher cost.

Monthly Family Income for

FAMILY SIZE	ADULTS	CHILDREN UNDER AGE 19	PREGNANT WOMEN
1	$ 776	$ 1,940	*
2	$ 1,562	$ 2,603	$ 2,082
3	$ 1,959	$ 3,265	$ 2,612
4	$ 2,357	$ 3,928	$ 3,142
5	$ 2,754	$ 4,590	$ 3,672
6	$ 3,152	$ 5,253	$ 4,202
7	$ 3,549	$ 5,915	$ 4,732
8	$ 3,947	$ 6,578	$ 5,262

** NOTE: Effective January 1, 2004. Income levels change annually. This is just a guide. Adults without children may have a lower income level. Pregnant women count as 2 when determining family size.*

How will I get my medical services?

People eligible for Family Health Plus and Child Health Plus B will receive their health care through health plans that have their own groups of doctors, hospitals and pharmacies. Before joining a plan, make sure your doctors are a part of that plan.

People eligible for Medicaid/Child Health Plus A/PCAP may also join a plan, or they may go to any doctor who accepts Medicaid or Child Health Plus A. You should talk to your doctor about what kind of health insurance he/she accepts.

What do I have to do to enroll?

It's now easier than ever to apply for health insurance. There are a lot of places in your neighborhood where you can get help. These places have experienced and friendly staff that are available on weekends and evenings to answer all of your questions and help you apply.

What is available for pregnant women?

New York State provides free health insurance for many pregnant women with limited income regardless of their immigration status under Medicaid and the Prenatal Care Assistance Program (PCAP). Pregnant women who participate in PCAP can receive a wide range of services designed to ensure a healthy pregnancy, including prenatal visits, health education, and specialty medical care. Services continue until two months after the pregnancy ends. Family planning services are available for 24 months after the pregnancy ends. After the baby is born, he or she will automatically receive health insurance for a year.

What is Women, Infants and Children (WIC)?

WIC is a program to improve the nutrition and health of women, and infants and children under age 5. WIC provides families with nutritious food, such as infant formula, milk, juice, cheese, eggs, cereal, dried beans/peas, and peanut butter. WIC also gives families nutrition and health education, and refers families to other health services. WIC is free for all eligible families.

What is the Family Planning Program?

This program covers health services and related drugs and supplies to maintain good reproductive health. Men and women of childbearing age may be eligible.

For Help Call:

To learn the nearest location where application assistance is available in your area, call:

For adults: 1-877-9FHPLUS

For children: 1-800-698-4543